Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Patients With Cervical Cancer

TO THE EDITOR: The article by Chu and coworkers[1] in the July issue reports on quality of care in women with stage I cervical cancer (invasive and noninvasive). The authors report but do not comment upon the lack of difference in outcome whether the patients received their preconceived optimum or less than optimum care. Their study would be greatly enhanced by knowing what forms of so-called nonoptimum care resulted in no increase in death rate or recurrence of the disease. Perhaps unknowingly they may have discovered a more cost effective method of treating patients with cervical cancer.

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REFERENCE

1. Chu J, Polissar L, Tamimi HK: Quality of care in women with stage I cervical cancer. West J Med 1982 Jul; 137:13-17

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Drs. Chu and Tamimi Respond

TO THE EDITOR: In response to Dr. Kornfield's letter, we would like to comment on three points.

First, the lack of difference in the survival between optimal and suboptimal care groups was addressed in the "Comment" section of the paper:

> The lack of difference in the three-year survival rates between the optimal and suboptimal care groups in stage IA cervical cancer is not surprising because most of the patients classified as suboptimal underwent simple hysterectomy for suspected carcinoma in situ and were diagnosed as having microinvasive cervical cancer from the pathologic specimen. So, even though patients did not have an optimal diagnosis, they did finally receive the standard definitive treatment. There was also no significant difference in survival rates between the optimal and suboptimal groups in stage IB. This lack of difference was probably due either to the short follow-up time or the possible efficacy of radiation immediately after simple hysterectomy, or both.[10,11]
>
> It should be noted that 22 women with stage IB cervical cancer in the suboptimal group received simple hysterectomy followed by radiation.

Second, although we did classify the women into optimal and suboptimal care groups, the criteria used for classification were not "ours." The criteria used were those recognized to be the "standard of care" by most experts in the field.

Third, our study is not designed to evaluate efficacy of different types of therapies for stage I cervical cancer, but rather to explore the different characteristics of patients, hospitals and doctors. Selection bias as well as other problems precludes the comparison of the survival rates to measure efficacy of treatment.

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Radiology and Medical Care Costs

TO THE EDITOR: This is in regard to the August 1982 article "The Costs and Risks of Medical Care."[1] As a practicing general radiologist, I have seen tremendous changes in diagnostic imaging over the past five years. I have a full-time job keeping up with the changes. There is now a tremendous overlap of diagnostic imaging available for certain disease states; for example, surgical versus medical jaundice, evaluation of pancreatic size, and the use of hypertensive pyelograms. Physicians order tests in a manner that was present in the medical training of 1960. That is, the attending physician orders hypertensive intravenous pyelograms, oral cholecystography or other studies. I am sure that if there was consultation between practicing physicians and the radiologists before the tests were ordered, the number of tests would decrease and the yield of information would increase. It has been suggested that a consulting radiologist in a department to plan the type of tests for diagnostic problems would decrease the costs of medical care. The high cost of imaging and the significant difference in yield

were pointed out in the lead article, concerning acute cholecystitis, in the August issue.[2]

Another problem is general practitioners with their own x-ray equipment. There is no doubt that this is a great money-maker and the cost of excess x-ray testing probably reaches millions of dollars in California alone. This is to say nothing about the lack of radiation control and film quality.

I think these two problems, when corrected, would decrease patients' costs.

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REFERENCES

1. McPhee SJ, Myers LP, Schroeder SA: The costs and risks of medical care—An annotated bibliography for clinicians and educators (Special Article). West J Med 1982 Aug; 137:145-161
2. Krishnamurthy GT: Acute cholecystitis: The diagnostic role for current imaging tests. West J Med 1982 Aug; 137:87-94

Waterborne Transmission of *Campylobacter*

Campylobacter organisms are a common cause of diarrheal illness, found in approximately 5 percent of stool specimens cultured for bacterial pathogens by the Washington State Public Health Laboratory. *Campylobacter* sp have been isolated from seawater[1] and waterborne transmission has been reported in three outbreaks.[2-4]

As a result of bacterial surveys of water supplies in Washington state, we have isolated *Campylobacter* organisms from three sources of raw surface water (lakes). In each case neither total nor fecal coliforms were significantly elevated in the samples and no source of contamination was identified. It is possible that infected waterfowl or other wildlife were responsible for the contamination.

Although *Campylobacter* infections usually cause symptoms distinctly different from those associated with giardiasis, the symptoms can be nearly indistinguishable. Since both infections may result from consumption of untreated surface water, both are possible causes of diarrheal illness among persons with a recent history of untreated water consumption. Exhibiting a shorter incubation period than giardiasis, *Campylobacter* infection should be considered in patients with diarrhea when untreated water has been consumed within seven days of the beginning of symptoms.

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REFERENCES

1. Knill M, Suckling WG, Pearson AD: Environmental isolation of heat-tolerant *Campylobacter* in the Southhampton area (Letter). Lancet 1978 Nov 4; 2:1002-1003
2. Mentzing LO: Waterborne outbreaks of *Campylobacter* in central Sweden (Letter). Lancet 1981 Aug 15; 2(8242):352-354
3. Waterborne *Campylobacter* gastroenteritis—Vermont. Morbidity Mortality Weekly Rep 1978; 27:207
4. Possible waterborne *Campylobacter* outbreak in British Columbia. Can Disease Weekly Rep 1981 Nov 7; 7(45):223-227

The Pot and the Kettle

TO THE EDITOR: Talk about the pot calling the kettle black!

MSMW must be steamed up about *encounter;* so much so, he doesn't see (in his August editorial)[1] the same evil in saying *lexicon* when he means *vocabulary*; isn't bothered a whit about preferring *professional happening* (happening!!) to *encounter*; and seems smug when he senses steps, especially steps that degrade semantically, and best of all, steps that degrade relationships.

Justifiably riled about *providers* and *consumers,* he uses the same claptrap when he has them *interacting professionally* (implying, I guess, that patients are professional), not to mention interacting in delivery. Narrowly escaping *hopefully,* he's so careful to say "it is to be hoped" that he forgets to stick a comma on both sides of a plainly independent clause.

He's so upset by *encounter* that he doesn't vomit when he says "meaningful doctor-patient relationship" (that's to distinguish it, I suppose, from meaning*less* relationships). Because of his distress, we can overlook *usage* when *use* would do nicely, but it's unforgivable to somehow justify the jargon he not only criticizes but uses, by saying that "language is made up of the words people use and the ways they use them." Stopping there ignores the corollaries that language can be simple, effective, direct, clear and beautiful, or it can be, as in his case, dull, trite, puffed-up, muddy and ugly. If I were Malcolm S. M. Watts, MD, and if I were editor of THE WESTERN JOURNAL OF MEDICINE, and if I wrote like that, I'd sign it MSMW, too, out of embarrassment—irrespective of whether I ever used the world *(sic).*

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REFERENCE

1. On having encounters with patients (Editorial). West J Med 1982 Aug; 137:129

EDITOR'S NOTE: Touché × 3(?)—Whoopee!!

—MSMW